# Kansas Department for Aging and Disability Services
## Nursing Facility Mental Health Education - Special Project
## Invoice-Summary

**Grant #:** _____

**Grantee Name:** _____ **Grant Period: From** _____ **to** _____

**Title of Course / Training Activity:** _____ **Billing period: From** _____ **to** _____

| Number of Individuals trained this invoice period: | | | | |
|---|---|---|---|---|
| **Unlicensed Staff** | **Licensed Staff** | **Total Staff** | **Unduplicated total # of facilities with employees attending training activity billed on this invoice** | **Total Amount Billed** |
| | | | | |

**ATTACH FORM KDOA 336a, Workforce Enhancement in Nursing Facilities - Special Project - Detail Invoice**

**I hereby certify:**
**1) The amount invoiced is for training of unlicensed staff currently employed by either a certified and licensed long-term care nursing facility (nursing home) or a long-term care unit of a hospital. No individuals employed in freestanding or attached Assisted Living Facilities, Residential Health Care Facilities, Home Plus Facilities, Boarding Homes, Home Health Agencies, Hospices, Hospitals and Hospital Swing Bed Units are included in this invoice.**

**2) To the best of my knowledge all training activities billed herein are in accordance with the Workforce Enhancement in Nursing Facilities, request for proposal, my agency's grant application and Notification of Grant award.**

**Authorized Official Name & Title:** _____ **Date Invoice Submitted:** _____

**(Please type or print Name & Title)**

**Signature of Authorized Certifying Official:** _____ **Phone:** _____

**Contact Person:** _____

**Kansas Department for Aging and Disability Services**
**Nursing Facilities Mental Health Education - Special Project**
**Invoice-Detail**

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**Grant #:** _____

**Grantee:** _____ **Presented by:** _____

**Title of Course/Training Activity:** _____ **Date of Session:** _____

**Name/Location of Facility:** _____

**Name/Address of Presentation:** _____

| | | | | | | CHECK ONE Employed in: | | No. of YEARS IN | |
|---|---|---|---|---|---|---|---|---|---|
| | Trainee/ Attendee | Position Title *(no abbreviations) | Certificate Number | License Number | Employer | Nursing Facility | Other | current position | employed in LTC |
| 1 | | | | | | | | | |
| 2 | | | | | | | | | |
| 3 | | | | | | | | | |
| 4 | | | | | | | | | |
| 5 | | | | | | | | | |
| 6 | | | | | | | | | |
| 7 | | | | | | | | | |
| 8 | | | | | | | | | |
| 9 | | | | | | | | | |
| 10 | | | | | | | | | |
| 11 | | | | | | | | | |
| 12 | | | | | | | | | |
| 13 | | | | | | | | | |
| 14 | | | | | | | | | |
| 15 | | | | | | | | | |

*May use Rn, LPN, CNA, CMA, SSD, AD. All other individuals needs to write out their position title.

## Kansas Department for Aging and Disability Services

## Nursing Facility Mental Health Education - Special Project
## Program Report

**Grant #:** _____

**Grantee:** _____

**Title of Course/Training Activity:** _____

**Report Period:** **From** _____ **To** _____

**PART I :** **Number of Eligible Individuals Trained by Employer**

| # of Individuals Trained | Employer |
|---|---|
| 1 _____ | _____ |
| 2 _____ | _____ |
| 3 _____ | _____ |
| 4 _____ | _____ |
| 5 _____ | _____ |
| 6 _____ | _____ |
| 7 _____ | _____ |
| 8 _____ | _____ |
| 9 _____ | _____ |
| 10 _____ | _____ |
| 0 | TOTAL NUMBER OF INDIVIDUALS TRAINED |

**Kansas Department for Aging and Disability Services**
**Nursing Facility Mental Health Education - Special Project**
**Program Report**

**PART II: Summary of Grantee progress in / toward implementation of grant activity.**

**PART III: Identify any Challenges encounter or lessons learned in connection with the implementation of this grant activity.**

**Kansas Department for Aging and Disability Services**
**Nursing Facility Mental Health Education - Special Project**
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**PART IV:** **Summarize Actions taken to overcome challenges encountered in implementation of grant activity.**

**PART V:** **Summary of recommendations.**